MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

36409

791
1003

1. PLACE OF DEATH

County.................... Registration District No.................... File No....................

Township.................... Primary Registration District No.... Registered No. **9986**

City **St. Louis Homer G. Phillips Hospital** (No.) .... St. .... Ward)

2. FULL NAME *Infant* Sykes

(a) Residence, No. **918 N 16th Street** St., **2 5** Ward. **1**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred ......yrs. ......mos. ......ds. How long in U. S., if of foreign birth? ......yrs. ......mos. ......ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)
M	Negro	—

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-25-37

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis,
(STATE OR COUNTRY) Mo.

13. NAME — (FATHER)

14. BIRTHPLACE (CITY OR TOWN) —
(STATE OR COUNTRY)

15. MAIDEN NAME Savannah Sykes (MOTHER)

16. BIRTHPLACE (CITY OR TOWN) St. Louis,
(STATE OR COUNTRY) Mo.

17. INFORMANT *Esther Mae Sherard*
(ADDRESS) 2601 N Whittier Street

18. BURIAL, CREMATION, OR REMOVAL
PLACE *City Cemetery* DATE 10/29/37, 19

19. UNDERTAKER *Ira Hamilton*
(ADDRESS) *City Health Dept.*

20. FILED OCT 27 1937 *J J Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-25-37 , 19

22. I HEREBY CERTIFY, That I attended deceased from ...., 19...., to ...., 19....

I last saw h.... alive on ...., 19...... Death is said to have occurred on the date stated above, at **5:45** A. M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Stillborn Prematurity	

Other contributory causes of importance:

Name of operation.................... Date of....................
What test confirmed diagnosis? **Clinical** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?.................... Date of injury...., 19......
Where did injury occur?....................
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury....................
Nature of injury....................

24. Was disease or injury in any way related to occupation of decedent?

If so, specify....................

(Signed) *Thomas C. McFall* , M. D.

(Address) *2601 N Whittier*